

# MAIL-IN APPLICATION INSTRUCTIONS

## INTRODUCTION

The application is to be completed for Healthy Families and/or Medi-Cal. This application will serve as the vehicle to collect all necessary information on:



- the applicant
- children/family members applying for coverage
- special medical needs of family members
- family size
- income and deduction information
- past medical expenses for Medi-Cal
- Enrollment Entity information for reimbursement
- plan choices for Healthy Families

**This application requires original signatures. Since each application is individually numbered with a barcode, an application should never be copied and used for a different family.**

If the applicant has children for which he/she is applying for or appears eligible for both programs, Single Point of Entry will duplicate the application so that one copy will be forwarded to the Healthy Families Enrollment Contractor and the original will be forwarded to the county Department of Social Services for no-cost Medi-Cal.

## MAILING THE APPLICATION

Envelopes are provided inside the application and no postage is required.

The Enrollment Entity/Certified Application Assistant should NEVER mail the application for the applicant.

## REVIEW OF APPLICATIONS

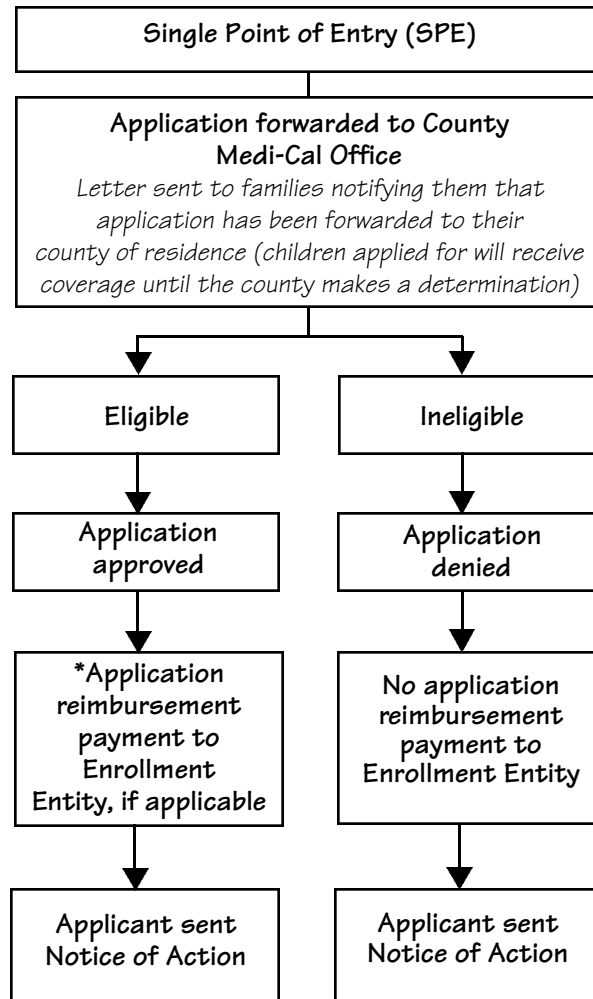
All applications are reviewed at Single Point of Entry. Federal regulations require a different set of rules be applied when determining income eligibility to families with members in the following categories:

- A child has separate countable income, such as Social Security or child support
- A child under age 18 has a child
- A stepparent or unmarried parent is part of the family size

In these instances, only the income of the child's natural or adoptive parents, plus the child's own countable income, is used when determining income eligibility. The income of a child's stepparent, caretaker relative, or sibling is not used.

In the above situations, the county Department of Social Services' assessment may qualify a child for no-cost Medi-Cal who otherwise appeared eligible for Healthy Families. Please advise the applicant that even though they may appear eligible for Healthy Families, the actual eligibility determination may qualify the family for no-cost Medi-Cal.

## ACCELERATED ENROLLMENT (FOR MED-CAL)



\*Application assistance reimbursement section (9) must be accurately & completely filled out (proposed elimination of reimbursements, effective 6/30/03)

## PROCESSING APPLICATIONS

The time periods for processing applications are based upon applications that are complete and all documentation is attached. The time periods are approximately, as follows:

<b>Single Point of Entry:</b>	Single Point of Entry (SPE) will screen the application within 4 working days and determine if it should be forwarded to Healthy Families Enrollment, the county Department of Social Services for Medi-Cal, or both.
<b>Medi-Cal:</b>	County Departments of Social Services have at least 45 days to process routine Medi-Cal applications.
<b>Healthy Families:</b>	The Healthy Families Enrollment Contractor will process a completed application within 20 calendar days of receipt from SPE

### ACCELERATED ENROLLMENT IN NO-COST MEDI-CAL

Effective July 1, 2002, children under 19 who pass screening at Single Point of Entry (SPE) for no-cost Medi-Cal will be granted temporary, fee-for-service, no-cost Medi-Cal coverage under the Medi-Cal Program. Accelerated Enrollment (AE) begins the first day of the month of the date SPE receives the application (e.g., SPE receives application 8/30/02, temporary, fee-for-service, no-cost Medi-Cal coverage is provided for the entire month of August 2002). Coverage continues until the county makes a determination of the child's eligibility for regular Medi-Cal.

In order for the Single Point of Entry to be able to enroll the child into this program, enough information must be provided on the application to identify the child (birth name, birth date, and gender). Once enrolled, a letter is mailed to the family explaining the program. This new process will ensure that children have access to medical coverage under the Medi-Cal Program while the County Social Services Department is making a complete determination of the child's eligibility under the Medi-Cal Program. Benefits Identification Cards (BIC) are sent from the fiscal intermediary directly to the household of the applicant and should arrive in 7 to 10 days after AE is established. This card can be used to access services. (More than likely this is true, but if sufficient information for mailing is not on the application, it will not get mailed.)



## APPLICATION

Please use the instructions to complete this application.  
Print clearly. Use black or blue ink only.



### SECTION 1: Tell us about the person applying for the child, the pregnant woman, the unborn child, or him or herself.

1 LAST NAME		FIRST NAME		MIDDLE INITIAL	2 BIRTHDATE MO / DATE / YR
3 HOME ADDRESS (NUMBER AND STREET). DO NOT USE A P.O. BOX				4 APARTMENT NUMBER	5 HOME PHONE # ( )
6 CITY		7 COUNTY	8 ZIP CODE		9 WORK PHONE # ( )
10 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX				11 APARTMENT NUMBER	12 MESSAGE PHONE # ( )
13 CITY				14 ZIP CODE	
15A WHAT LANGUAGE DO YOU SPEAK BEST?			15B WHAT LANGUAGE DO YOU READ BEST?		

16 We will enroll the child or pregnant woman in the program they qualify for. If you do not want to be enrolled in one of these programs, check the box(es) below.

I DO NOT WANT: ☐ Healthy Families: Do not send birth certificates. Do not complete the Healthy Families Page.  
☐ Medi-Cal

### SECTION 2: Tell us about the children under 19 and/or the pregnant woman who want health coverage.

	Child 1 or Unborn Check box <input type="checkbox"/> if unborn	Child 2	Child 3	Child 4	Pregnant Woman
17 Name:	Last				
	First				
	Middle				
18 Name on Birth Certificate: (if same as #17 above, leave blank.)	Last				
	First				
	Middle				
19 If the child's address is not the same as in Section 1, Question 3, give complete address:					
20 Relationship to person in Section 1:					
21 Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
22 Date of Birth:	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR
23 Place of Birth: County or State or Country, if outside the U.S.					
24 Ethnic Code: (See #24 Instructions)					
25 U.S. Citizen or National? If "no", please write date of entry into U.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR
26 Social Security #:					

Social Security Numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only.

**SECTION 2: Continued**

	Child 1 or Unborn	Child 2	Child 3	Child 4	Pregnant Woman
Check box <input type="checkbox"/> if unborn					
27 Mother's Name: Last					
First					
Does the mother live in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
28 Father's Name: Last					
First					
Does the father live in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
29 Name of teen's spouse or pregnant woman's husband: (if living in the home)					
30 Does any person(s) being applied for have no-cost Medi-Cal? If "yes", give date coverage ends/ended.	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DAY / YR
31 Does the pregnant woman and/or children have other health, dental or vision insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
32 Were any of the children insured by an employer in the last 90 days? If "yes", check the main reason why health insurance stopped and give the date it stopped.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DAY / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DAY / YR

**SECTION 3: Family members living in the home. Family size is taken into consideration when determining which program your children are eligible for.**

33 List any other children living in the home under age 21 who are not listed in Section 2. Give their relationship to the person in Section 1, Question 1.	
LAST NAME, FIRST NAME	RELATIONSHIP
LAST NAME, FIRST NAME	RELATIONSHIP
LAST NAME, FIRST NAME	RELATIONSHIP
LAST NAME, FIRST NAME	RELATIONSHIP
34 Are any family members who are living in the home pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who: _____ Date Due: _____	
35 List any stepparent living in the home not already listed: _____	
LAST NAME, FIRST NAME	
36 Do any of the people listed in this Section, or any of the parents listed in Section 2, want Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION 4: List the gross income (before taxes) of all persons listed in Section 2, Questions 17, 27, 28, 29 and Section 3 who live in the home. If self-employed or using federal income tax return to prove income, only complete Questions 37, 38 and 40 in this section.**

37	NAME OF PERSON WITH INCOME	38	SOURCE OF INCOME?	39	HOW OFTEN RECEIVED?	40	HOW MUCH GROSS INCOME?	41	SOCIAL SECURITY # (Optional)
1.									
2.									
3.									
4.									

**SECTION 5: Deductions from Family Income. The answers in this section will help determine what amounts will be deducted from your family's gross monthly income.**

42	TYPE OF PAYMENT YOUR FAMILY MAKES	43	NAME OF PERSON WHO PAYS	44	MONTHLY AMOUNT PAID
	Child Support				
	Alimony				

45	CHILD CARE OR DEPENDENT CARE (List child's name)	46	AGE	47	MONTHLY AMOUNT PAID
1.					
2.					
3.					
4.					

**SECTION 6: Other Coverage.**

48 Has anyone filed a lawsuit because of an accident or injury on behalf of the pregnant woman and/or child applying for benefits? ☐ Yes ☐ No

49 Does the pregnant woman and/or child want to apply for Medi-Cal coverage for any medical expenses in the last 3 months? ☐ Yes ☐ No

If "yes", list month(s): \_\_\_\_\_

**SECTION 7: Voluntary Information. Not required. Your answers will not affect your eligibility but they will help the state to get additional federal money to pay for health care programs.**

50 Is there more than one car in the children's household? ☐ Yes ☐ No

51 Is there more than \$3,150 cash in bank accounts in the children's household? ☐ Yes ☐ No

**SECTION 8: Signature and Certification.**

52 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If person signed with a mark)

Authorized Representative (If any) \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 9: Reimbursement for Application Assistance. For Certified Application Assistant use only.**

53 I certify I had help completing this form from the Certified Application Assistant listed below. This CAA help was **FREE** of charge. The state will not issue a reimbursement to the EE unless Section 9 is completely and correctly filled out at the time this application is submitted.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

CAA Signature \_\_\_\_\_ CAA# \_\_\_\_\_ EE# \_\_\_\_\_ Date \_\_\_\_\_



If it appears you qualify for **Healthy Families** and want to choose your health, dental and vision plan now, fill out this page. Otherwise, we will contact you later for this information. See your **Healthy Families Handbook** for more information, or visit our web site at [www.healthyfamilies.ca.gov](http://www.healthyfamilies.ca.gov).

#### SECTION A: Health, Dental and Vision Plan Choices.

54	Health Plan/Code	55	Dental Plan/Code	56	Vision Plan/Code
57	Name of Doctor/Clinic (optional)	58	Doctor/Clinic Code (optional)	59	Name of Dentist/Clinic (optional)
				60	Dentist/Clinic Code (optional)

#### SECTION B: Rural Demonstration Project.

61	<p>If you are in any of these groups, there is a new statewide health, dental and vision plan combination offered to you. You can pick this new combination and put the code in the box below. See the <b>Healthy Families Handbook</b> for the combination code number.</p> <p>Check all boxes that apply to you.</p> <p><input type="checkbox"/> Native American Indian   OR   Working in seasonal or migratory jobs:   <input type="checkbox"/> Agriculture   <input type="checkbox"/> Forestry   <input type="checkbox"/> Fishing</p>	Plan Combination Code
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#### SECTION C: Healthy Families Declarations

<p><b>I declare that each person I am applying for:</b></p> <ul style="list-style-type: none"><li>• is a resident of California.</li><li>• is not in jail or in a mental hospital.</li><li>• is not eligible for Medicare Part A and Part B.</li><li>• is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).</li></ul> <p><b>I further declare that:</b></p> <ul style="list-style-type: none"><li>• all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled.</li><li>• I have read and understand the <b>Healthy Families Handbook</b>. I understand what it says about each health, dental and vision plan and the benefits they offer.</li></ul>	<ul style="list-style-type: none"><li>• I am applying for all of my children eligible for <b>Healthy Families</b>, unless they are already enrolled, or I am 18 years old or a minor and applying for myself.</li><li>• I agree to pay 6 monthly premiums. If I do not pay the premiums, I will be taken off the program and cannot participate again for 6 months. I will have to pay for any <b>Healthy Families</b> services I use in the last month after coverage ended.</li><li>• I give permission to <b>Healthy Families</b> to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this application.</li><li>• I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.</li></ul>
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#### SECTION D: Privacy Notice.

<p>The Information Practices Act of 1977 and the Federal Privacy Act require the <b>Healthy Families</b> Program to provide the following notice to individuals who are asked by <b>Healthy Families</b> to supply information:</p> <p>Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the <b>Healthy Families</b> Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs. Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.</p> <p>The following information on the application is not mandatory: social security number, ethnicity information (unless the subscriber is a Native American Indian) and any other item marked voluntary or optional. An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Room 450, Sacramento, California 95814, (916) 324-4695.</p>
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#### SECTION E: Resolving Disputes.

<p>If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The <b>Healthy Families Handbook</b> has information about each plan and the arbitration requirements. You may call the plans you choose to find out more.</p>
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#### SECTION F: Signature and Certification.

62	<p>I certify that I have read and understand the information above. I also certify that the information I have given on this form is true and correct.</p> <p>Signature _____ Date _____</p> <p>Witness Signature _____ Date _____</p> <p>(If person signed with a mark)</p>
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## SECTION 1, APPLICANT INFORMATION

The numbered boxes in the following sections apply to the corresponding question on the application.

### **1** Applicant Name

List the last name, first name, middle initial of the applicant (the person who will be signing the application). The applicant can be a person who is:

- Natural or adoptive parent, whether or not living with child (Manual page 3-2)
- Legal guardian, will have a court order or other legal status which gives authority for health care decisions
- Caretaker relative, such as a grandparent, aunt, cousin, sibling, or other family member who the child resides with and who exercises the primary care and control of the child
- Foster parent
- Stepparent
- A person applying for coverage on his or her own behalf

Children under age 18 may apply for coverage on their own if they are over age 14, are not living with a parent or caretaker relative, legal guardian, foster parent, or step-parent.

When a parent age 18 or younger has his or her own child, he or she may complete an application for the child.

### **2** Applicant's Birthdate

Enter the birthdate of the applicant as shown, month — day — year

### **3** Home Address

Enter the street address, road, rural route, or other physical description for the applicant.  
***Do not enter a P.O. Box address.***

### **4** Apartment Number

Enter the apartment or unit number, if applicable. If not applicable, leave blank.

### **5** Home Phone #

Enter the home phone number, including area code of the applicant. If there is no home phone, leave blank.

### **6** City

Enter the city in which the applicant lives.

### **7** County

Enter the county in which the applicant lives.

**8 Zip Code**

Enter the zip code in which the applicant lives.

**9 Work Phone #**

Enter the applicant's work phone number. Leave blank if there is no work phone number.

**10 Mailing Address**

Enter the mailing address, if different from the address in #3. This is where a P.O. Box address should be entered. Leave blank if there is not a different mailing address.

**11 Apartment Number**

Enter the apartment or unit number of the mailing address. Leave blank if not applicable.

**12 Message Phone Number**

Enter the message phone number, if applicable. Leave blank if there is no message phone number. Please note that at least one of the phone numbers should be entered so that the applicant can be contacted in case clarification or further information is needed.

**13 City**

Enter the city of the mailing address. Leave blank if there is no alternate mailing address.

**14 Zip Code**

Enter the zip code of the mailing address. Leave blank if there is no alternate mailing address.

**15A Language Spoken Best**

Enter the language which the applicant speaks best. This information will be used if the applicant needs to be contacted by telephone. Representatives are available in all threshold languages, as well as in others.

**15B Language Read Best**

Enter the language which the applicant reads best. This information will be used for any written correspondence which needs to be sent to the applicant.

**16 Programs Not Applying For**

The applicant can check the box to identify the programs(s) that they **DO NOT** want to be considered for. Families are encouraged not to check any box so that family members can be evaluated for any program for which they qualify.

*Example:* If the applicant checks "do not want Medi-Cal", but children are eligible for no-cost Medi-Cal, the application will not be forwarded to the County and the children will not receive health coverage.

## SECTION 2, INFORMATION ABOUT CHILDREN/PREGNANT WOMAN

Section 2, Questions 17-32, will ask for information about the child(ren), unborn, and/or pregnant woman who want health coverage.

The applicant may apply for Healthy Families for an unborn child within 3 months of the due date. If the family income is too high for the pregnant woman to receive No Cost Medi-Cal but the family income is within the eligibility level for “Child Birth Up To Age 1” for Healthy Families (below 250% of the Federal Income Guidelines), the unborn child may be eligible for Healthy Families. In this situation, use the “Child 1 or Unborn” column and complete as much information as is known in this column (Questions 22, 27, and 28).

The application allows room for four children plus a column to be used for a pregnant woman. If this column is not needed, it can be used for a fifth child. In that instance, cross out the column heading and write above it “Child 5.”



### 17 Name

List the name (last, first, middle) of each child and/or pregnant woman applying for health coverage. Leave blank for an unborn child in column 1.

### 18 Name on Birth Certificate

List the name exactly as it appears on the birth certificate. Leave blank for an unborn child in column 1.

### 19 Child's Address

Enter the child's address if the child is not living with the applicant. The child(ren) and/or pregnant woman must live in California to be eligible for both Medi-Cal and Healthy Families. Leave blank for an unborn child in column 1.

### 20 Relationship to Person in Section 1

List the relationship of the child/pregnant woman to the applicant listed in Section 1, such as son, granddaughter, step daughter, nephew, etc. This information will help Single Point of Entry determine the family size. Leave blank for an unborn child in column 1.

### 21 Sex

Check the appropriate box to indicate the sex of the child. Leave blank for an unborn child in column 1.

### 22 Date of Birth

Enter the birthdate of the child/pregnant woman as shown, month • date • year. Enter the expected due date for an unborn child in column 1.

### 23 Place of Birth

Enter the county (in California) or state (outside California) where the child/pregnant woman was born. If born outside the U.S., enter the country. Leave blank for an unborn child in column 1.

## 24 Ethnic Code

Ethnic codes are listed on page 3 of the application instructions. While the information is optional, it is important because it helps Department of Health Services and MRMIIB to determine the effect of outreach and advertising campaigns.

Native American Indians and Alaskan Natives must enter their ethnic code. A cost sharing waiver from premium payments and co-payments is available to Native American Indians and Alaskan Natives for Healthy Families. Leave blank for an unborn child in column 1.

## 25 U.S. Citizen or National

Check the “yes” or “no” box to indicate if the child/pregnant woman is a U.S. Citizen or National. U.S. Citizens/Nationals include:

- Born in the U.S.
- Native American born in Canada
- Born in Puerto Rico
- Born in Northern Mariana Islands
- Born in Guam
- Born in the Virgin Islands of the U.S. (St. Thomas, St. John, and St. Croix)
- Born in Swain’s Island
- Naturalized Citizen
- Acquired Citizenship or Derived Citizenship
- Born in American Samoa



Check the “no” box if the child/pregnant woman is not a citizen or a National of the U.S. If the “no” box is checked, enter the date of entry into the U.S. See Chapter 8 of this manual for information regarding types of immigration status and confidentiality. Leave blank for an unborn child in column 1.

## 26 Social Security Number

***A Social Security number is not required to receive benefits under Healthy Families.***

Enter the Social Security number of the child/pregnant woman when applying for Medi-Cal.

Children or pregnant women who are not eligible for full-scope Medi-Cal because of their immigration status, and who do not have a Social Security number, can still get pregnancy related and emergency benefits if they meet all other eligibility requirements. Family members seeking full-scope Medi-Cal benefits must provide (or apply for) a Social Security number to be eligible.

If an applicant does not provide a Social Security number when they complete the application, it should still be forwarded for processing. Leave blank for an unborn child in column 1.

## 27 Mother's Name

List the natural (or legal adoptive) mother. If the mother’s name is the same for all children, write the name in the “Child 1” column then write “same” for the remaining children. This information is not applicable for the pregnant woman who is over 19 years old.

Check box to indicate whether the mother lives in the home.

## **28** Father's Name

List the natural (or legal adoptive) father. If the father's name is the same for all children, write the name in the "Child 1" column then write "same" for the remaining children. This information is not applicable for the pregnant woman who is over 19 years old.

Check box to indicate whether the father lives in the home.

## **29** Teen's Spouse/Pregnant Woman's Husband

List the name of the teen's spouse or pregnant woman's husband if they live in the home and are not already listed in #28. Leave blank for an unborn child in column 1.

## **30** No-Cost Medi-Cal

Check "yes" or "no" to indicate if the child or pregnant woman is currently receiving no-cost Medi-Cal. If yes, enter the date no-cost Medi-Cal coverage will end. Leave blank for an unborn child in column 1.

Children who are receiving no-cost Medi-Cal are not eligible for Healthy Families.

**NOTE:** It's important to accurately determine if the child or pregnant woman is already on no-cost Medi-Cal. CAA's can begin by asking if the applicant has a "Benefits Identification Card", copy shown on Page 6-8. If the answer is yes, the CAA can continue by asking:

- Does the applicant have a Notice of Action from the County Department of Social Services stating that benefits have been/will be discontinued?
- Does the applicant have to pay for a portion of services (this would mean that Medi-Cal coverage is with a share of cost for the child who is being applied for)?

**NOTE:** A child on Medi-Cal with a share of cost is eligible for Healthy Families.

## **31** Other Health, Dental, or Vision Insurance

Check "yes" or "no" to indicate if the child or pregnant woman has other health, dental, or vision insurance. For example, if only the applicant parent has health coverage through an employer and the child is uninsured, the answer would be "no." Leave blank for an unborn child in column 1.

**NOTE:** The child or pregnant woman can have other health insurance and still be eligible for Medi-Cal.

## **32** Employer-Sponsored Insurance

Check "yes" or "no" to indicate if the child or minor applying on their own behalf for Healthy Families has been insured by an employer-sponsored health plan in the last 90 days. If yes, check the box next to the reason coverage ended and write the date the insurance ended. See page 5-2 for more information. Leave blank for an unborn child in column 1.

## SECTION 3, OTHER FAMILY MEMBERS

This section will identify other family members who have not already been listed in Sections 1 and 2. This information is necessary to correctly determine family size.

### **33** Other Children Living in the Home

Typical examples of children who would be listed here are:

- Children who already have health coverage
- Children between the age of 19 - 21 who live in the home
- Dependent children under the age of 21 who are away at school

Do not list children on SSI or public assistance in this section because they will not be counted in the family size.

### **34** Pregnant Family Members

Other than the pregnant woman listed in Section 2, list here if another family member is pregnant. An example would be a pregnant teen in the home. This also determines family size because the unborn child counts as an additional family member.

**NOTE:** Information entered here can also expedite the processing of the Medi-Cal application for pregnant women. Women who have a late-term or high-risk pregnancy should apply directly at their local Medi-Cal office for a faster determination of their eligibility.

### **35** Stepparent in the Home

List the name (last, first), of a stepparent living in the home.

- Do not list stepparent if they were listed in #27 or #28 as the parent of a child
- Only list the stepparent by marriage, not a live-in partner

### **36** Other Family Members Who Want Medi-Cal

Check “yes” or “no” to indicate if any of the family members listed in Section 3 want Medi-Cal.

## SECTION 4, INCOME INFORMATION

The information listed in this section will be used to determine family income and ultimately program eligibility.

### **37** Name of Person With Income

List the family member with income.

- If one family member has more than one source of income, list the name on more than one line as necessary
- Child support should be listed as the child's income
- Do not list family members who are not included in the family count, such as family members who receive SSI/SSP, General Relief, or public assistance
- It is not necessary to list the income of a stepparent listed in Section 3, #35

### **38** Source of Income

List the source of income. See pages 3-3 through 3-4.

Do not list income which is not counted, See page 3-5.

### **39** How Often Received

List how often each source of income is received. Note the difference between paychecks received every two weeks and paychecks received twice per month.

### **40** Gross Income

List the gross income amount (before taxes). For self employment, list the positive amount shown on line 12 of the Federal Tax Form. See pages 3-13 through 3-17 for more information.

### **41** Social Security Number

Enter the Social Security Number of the person(s) with income. This information is optional for Healthy Families and Medi-Cal.

## SECTION 5, INCOME DEDUCTIONS

### **42** Type of Payment

Child support or alimony paid. No entry needed, continue to #43.

### **43** Name of Person Who Pays

List the name of the family member who pays court-ordered child support and/or alimony.

### **44** Monthly Amount Paid

List the court-ordered amount or actual amount paid per month, whichever is less.

### **45** Child Care or Dependent Care

List the name for whom child care/dependent care is paid.

### **46** Age

List the age of the child.

### **47** Monthly Amount Paid

List the amount paid per month for child or dependent care. The maximum amount which can be deducted from monthly income is:

- Up to \$200 per child under 2 years of age
- Up to \$175 per child 2 years of age and over
- Up to \$175 per disabled dependent

## SECTION 6, OTHER COVERAGE

### **48** Lawsuit on Behalf of the Child or Pregnant Woman

Check the box to indicate if a lawsuit has been filed because of an accident or injury caused by another person or while at work. Medi-Cal can be used to get services that are necessary because of the accident. However, if the person receives an insurance, or other type of settlement, they must repay Medi-Cal for the medical costs provided due to the injury. Only those costs for services associated to the injury must be repaid. No costs need to be repaid if the person does not receive a settlement.

## **49** Medi-Cal Coverage for Previous Medical Expenses

Medi-Cal may pay for past medical expenses if the applicant or child(ren) have medical expenses during the 3 months prior to the date of application. When the application is received, the county Department of Social Services will request additional information from the applicant. Even children who are eligible for Healthy Families can be eligible for assistance with past medical expenses from Medi-Cal.

Single Point of Entry will forward a copy of the application to the county Department of Social Services to process the information for retroactive Medi-Cal.

**NOTE:** To receive this coverage, Question 16, “do not want” Medi-Cal box must NOT be checked.

*Example:* In June, the applicant reports that a child, Andrew, broke an arm in April. There were medical expenses in April and May that have not been paid. If all eligibility requirements are met for retroactive coverage, Andrew’s medical expenses may be covered by Medi-Cal.

**NOTE:** It is recommended that the applicant go to the county Department of Social Services to complete the application for retroactive (past) medical expenses when:

- It is the last week of the month and there is a chance the application will not reach the Single Point of Entry before the first of the following month, and
- The applicant has requested medical coverage for the earliest of the past three months. If the mail-in application is completed on 1/28/03, there is a chance the application will not be received by the Single Point of Entry before 2/2/03, which becomes the date of application. The earliest of the three months of past medical expenses might not be covered if the application does not reach the county Department of Social Services in January.

Applicants for retroactive Medi-Cal coverage will be sent a one-page form to complete and must verify all income received in the month(s) coverage is requested.

## **SECTION 7, VOLUNTARY INFORMATION**

This information is *voluntary and will not affect eligibility*. The application simply asks for a “yes” or “no” response. Answers to these questions will help California to claim federal funds for its health care programs.

### **50** More Than One Car

Indicate whether there is more than one car in the children’s household.

### **51** More Than \$3,150 Cash in Bank Accounts

Indicate whether there is more than \$3,150 cash in bank accounts in the children’s household.

## SECTION 8, SIGNATURE AND CERTIFICATION

### **52** Signatures

The applicant signs and dates on this line. Explain that when the applicant signs “under penalty of perjury” he or she can be prosecuted for information knowingly misrepresented on the application.

- The signature of the witness is necessary if the applicant signs with a mark, such as an “X”

## SECTION 9, REIMBURSEMENT FOR APPLICATION ASSISTANCE

### **53** For Certified Application Assistant Use Only

The applicant signs and dates to verify that they were assisted with the application by a certified application assistant. The CAA also signs, dates, and enters the CAA# and EE#.

- The nine-digit identification number for the CAA, as well as the five-digit number for the EE are needed to match processed/approved applications to the Enrollment Entity. If the EE or CAA number is missing or incomplete, the EE will not receive reimbursement.

**Section 9: Reimbursement for Application Assistance. For CAA use only.**

**53** I certify I had help in completing this form from the CAA listed below. This CAA help was FREE of charge. The state will not issue a reimbursement to the EE unless Section 9 is completely and correctly filled out at the time this application is submitted.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

CAA Signature \_\_\_\_\_ CAA# \_\_\_\_\_ EE# \_\_\_\_\_ Date \_\_\_\_\_

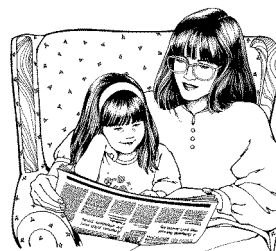
### **IMPORTANT:**

Section 9 must be correctly and legibly completed, including signatures and numbers (include all leading zeros), at the time the application is submitted for the Enrollment Entity to receive the reimbursement (proposed elimination of reimbursements, effective 6/30/03).

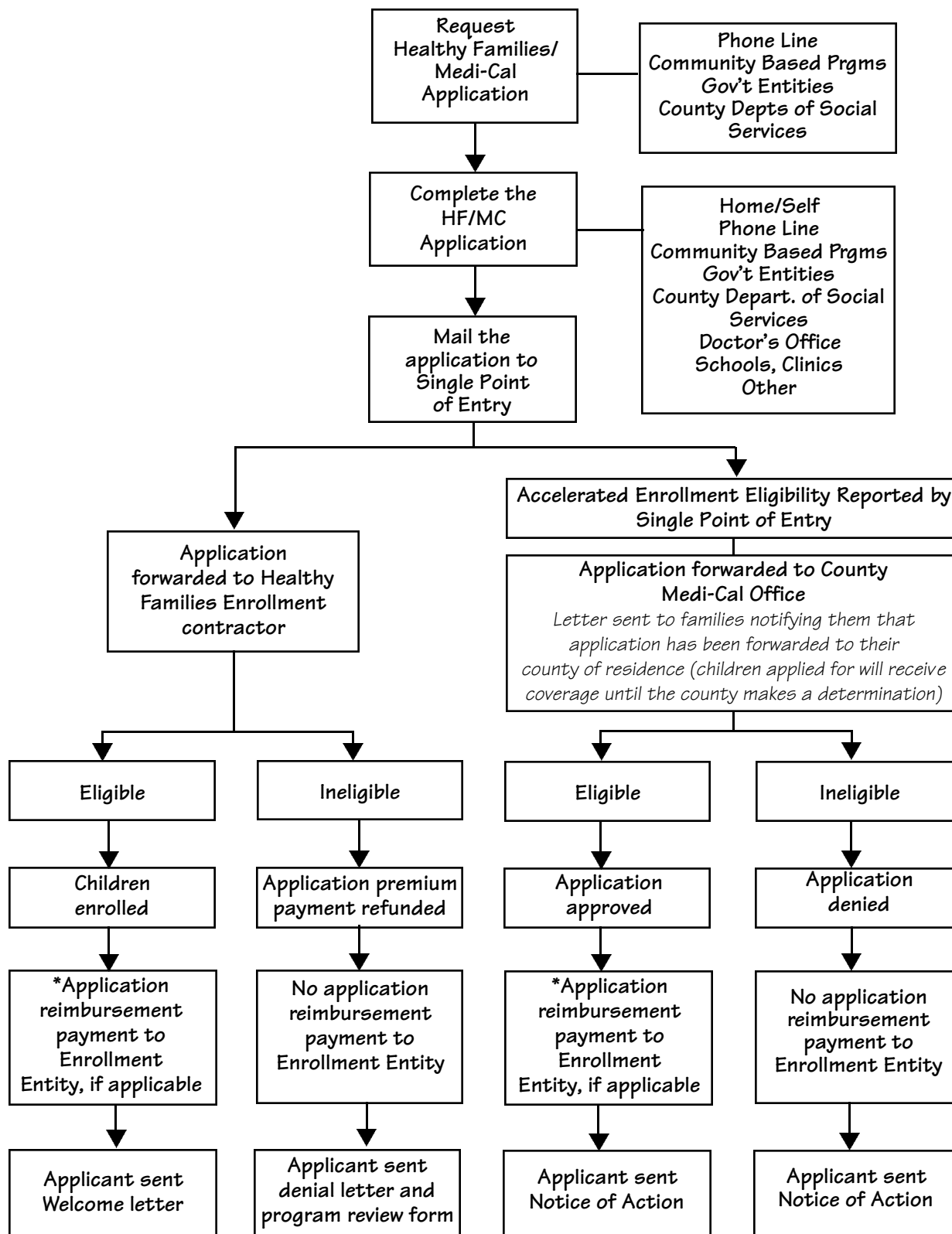
## APPLICATION PAGE A4, SECTIONS A – F

### **54** - **62** Healthy Families

Page A4 of the application pertains to Healthy Families. Instructions for completing this page are in Chapter 6, beginning on page 6-4.



# GENERAL OVERVIEW OF APPLICATION PROCESS



\*Application assistance reimbursement section (9) must be accurately & completely filled out (proposed elimination of reimbursements, effective 6/30/03)